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REFERENCES


Association of Primary Care Physician Relationship and Insurance Status With Reduced Rates of Tobacco Smoking

To the Editor:

In order to determine whether an existing primary care provider (PCP) relationship was associated with reduced rates of tobacco smoking, we carried out an anonymous self-reporting survey of all noncritically ill adults seen in the Creighton University Medical Center ED during March and April of 2008. This nonvalidated, institutional review board-approved survey assessed tobacco smoking history, PCP relationship status, and third-party payer status. The survey was completed by 501 of approximately 2,500 patients, for a participation rate of approximately 20% during the study period.

Of patients with a PCP relationship, 26.5% were current tobacco smokers compared with 62.3% of patients without a PCP. A total of 54.8% of patients without insurance reported current smoking compared with 55.4%, 25.9%, and 21.4% of Medicaid, private insurance, and Medicare patients, respectively (Table 1). Although lack of an established PCP relationship and the absence of a third-party payer source were correlated ($r^2 = 0.71, P = .001$), both variables were independent predictors of current tobacco use using multivariate logistic regression modeling (absence of a third-party payer adjusted OR = 1.3 [$P = .002$] and lack of a PCP relationship adjusted OR = 5.2 [$P < .001$]). This finding implies that insurance status does not serve as a simple proxy for access to health care by a PCP and that the relationship among tobacco smoking, an established PCP relationship, and the availability of a third-party payer are more nuanced.

An interesting observation in this cohort was that a significant portion of the between-group difference in the rate of current tobacco smoking was increased cessation among those with a PCP relationship and/or a third-party payer. Rates of never smokers were consistent across groups when stratified by PCP or insurance status. The exception to this generalization was the Medicaid group, which had a significantly lower percentage of never smokers (16.2%) compared with other groups (34.7%-40.5%). Unmeasured socioeconomic variables may contribute to this finding.

Tobacco smoking cessation rates were drastically improved in the groups with a PCP and/or a third-party payer, and these patients used a more robust complement of cessation modalities. These observations suggest that access to a PCP increases the likelihood of individualized, multimodality prescription medications and that a third-party payer provides financial assistance for access to additional modalities of cessation. The implication that the deleterious effects of tobacco smoking can be mitigated by increasing access to a PCP and ensuring a third-party payer source to subsidize preventative therapies is significant when

Table 1—Comparisons of Primary Care Provider Relationship Status, Tobacco Use, and Smoking Cessation Methods by Insurance Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>None</th>
<th>Private</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP status</td>
<td>211</td>
<td>116</td>
<td>98</td>
<td>74</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>No</td>
<td>174 (82.5)</td>
<td>7 (6.0)</td>
<td>11 (11.2)</td>
<td>15 (20.3)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37 (17.5)</td>
<td>109 (94.0)</td>
<td>87 (88.8)</td>
<td>50 (79.7)</td>
<td></td>
</tr>
<tr>
<td>Tobacco use</td>
<td>210</td>
<td>116</td>
<td>98</td>
<td>74</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>Current</td>
<td>115 (54.8)</td>
<td>30 (25.9)</td>
<td>21 (21.4)</td>
<td>41 (55.4)</td>
<td></td>
</tr>
<tr>
<td>Former</td>
<td>15 (7.1)</td>
<td>30 (33.6)</td>
<td>43 (43.9)</td>
<td>21 (28.4)</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>80 (38.1)</td>
<td>47 (40.5)</td>
<td>34 (34.7)</td>
<td>12 (16.2)</td>
<td></td>
</tr>
<tr>
<td>Means of cessation</td>
<td>15</td>
<td>39</td>
<td>41</td>
<td>21</td>
<td>$&lt;.001$</td>
</tr>
<tr>
<td>No help</td>
<td>13 (86.7)</td>
<td>13 (33.3)</td>
<td>18 (43.9)</td>
<td>11 (52.4)</td>
<td></td>
</tr>
<tr>
<td>Prescription medication(s)</td>
<td>0</td>
<td>10 (25.6)</td>
<td>7 (17.1)</td>
<td>4 (19.0)</td>
<td></td>
</tr>
<tr>
<td>Nicotine replacement</td>
<td>2 (13.3)</td>
<td>12 (30.8)</td>
<td>7 (17.1)</td>
<td>4 (19.0)</td>
<td></td>
</tr>
<tr>
<td>Alternative medicine</td>
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<td>2 (5.1)</td>
<td>4 (9.8)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>0</td>
<td>2 (5.1)</td>
<td>9 (21.9)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4 (19.0)</td>
<td></td>
</tr>
</tbody>
</table>

PCP = primary care physician.
$^*$Values given are No. or No. (%).

Correspondence
Thrombocytosis in Patients With Severe Community-Acquired Pneumonia

To the Editor:

In a recent article in CHEST (February 2010), Mirsaeidi and colleagues found that thrombocytosis (platelet count >400,000 cells/μL) at the time of hospital admission was a strong predictive factor of mortality in a population of 500 patients with community-acquired pneumonia (CAP). These results contrast with those of numerous previous studies in which thrombocytopenia was the main platelet disorder associated with worse clinical outcome.1-4 We believe this conclusion could be explained by the moderate severity of CAP. Among the studied population, only 58% of patients belong to pneumonia severity index risk class 4 and 5, and admission to an ICU concerned only 17.2% of patients. Mortality was relatively low at 10.8% of patients. The authors recommended new studies focusing on the cause of death to determine if an elevated platelet count in patients with CAP is just a marker of the inflammatory response or if it is in part responsible for an increase in mortality. We have recently published a multicenter retrospective study showing, in 822 patients admitted to an ICU for severe CAP, that severe thrombocytopenia (<50,000 cells/μL) was an independent predictor of mortality.5 We looked at the impact of thrombocytosis in our patients. The overall ICU mortality rate was 35.4%. Thrombocytosis was present in 70 (5.7%) patients. Among these patients, 24 (34.3%) died. We did not find any difference in outcome compared with patients with thrombocytosis (P<.7). Our patients were more severely ill, with mechanical ventilation required within 12 h following ICU admission in 77.6% of patients and septic shock present in 30.4% of patients. When considering the cause of death according to platelet numbers, we found it was essentially related to sepsis complications in patients with thrombocytopenia (septic refractory shock, n=18; multiorgan failure, n=17; ARDS, n=11; nosocomial pneumonia, n=8), while in patients with thrombocytosis, the cause of death was mostly related to complications of ICU stay or associated comorbidity (P<.007; COPD, n=3; cerebral vascular ischemia, n=2; cancer, n=2; mesenteric ischemia, n=1; myocardial infarction, n=1) (Table 1).

Thus, we believe that thrombocytopenia remains an important predictor of outcome in patients with severe CAP. In these patients, thrombocytosis is not associated with worse outcome.

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Nicolas Brogly, MD
David Olive, MD
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References

Response

To the Editor:

We agree with Georges and colleagues that in hospitalized patients requiring ICU admission for severe community-acquired pneumonia (CAP), the presence of severe thrombocytopenia should be considered a risk factor for mortality. A low platelet count is a marker of severe sepsis and may indicate the presence of disseminated intravascular coagulation. In our recent article,